PI - REVIEW PROCESS - SUMMARY OVERVIEW

Purpose:

This procedure provides an overview of the process used to accept and conduct reviews.

Identification of Roles:

IME Program Integrity (PI) Unit—provide surveillance and utilization case reviews on providers.
IME Units—serve as resource to Reviewer for specific case review as needed.

Performance Standards:

None

Path of Business Procedure:

Identification of potential review cases or projects may originate with any PI staff, an IME source outside of the unit (e.g., Provider Services, Member Services, Waiver Programs), or any external referral (refer to procedure, "Identification of Provider Reviews"*).* PI Reviewers maintain a dual focus throughout provider review, a detailed perspective (e.g., Iowa Administrative Code, claims data, and provider documentation) and a broad perspective (systems problems involving policy, education, Medicaid Management Information System (MMIS), or IME operations issues)

Step 1. The Account Manager, Operations Manager, and Database Management Administrator, identify potential reviews through the quarterly provider review work plan, analysis of routine and requested reports from the Surveillance & Utilization Review Services (SURS) Sub-System, and other databases and referrals.

Step 2. SURS reviews are entered into the PI Database by the Account Manager or Operations Manager.

Step 3. The PI Database is used to organize the review process into five levels. As the review progresses, the Reviewer updates the data file in the PI Database ("refer to Review Algorithm," Exhibit 1).

☑ LEVEL 1: Date Case Assigned by Supervisor

Step 1. The Senior Reviewer assigns specific review and project assignments to the Reviewer. The Senior monitors reviewer workload and case distribution (refer to procedure, "Assignment of Reviews and Projects").

Step 2. The Senior Reviewer ensures that all information leading to the assignment of the case is given to the Reviewer. This may include information from PI Subsystem Reports, Data Warehouse queries, or referral information.

☑ *LEVEL 2: Date Preliminary Review Began*

Step 1: Based on results of a preliminary review or on analysis of available information on case assignment, the Reviewer makes a recommendation for case dispensation. The recommendation may be any of the following.

a. Closure, no further review is indicated
b. Claims review only
c. Medical records review
d. On-site review
e. Provider education
f. Referral to Medicaid Fraud Control Unit (MFCU)
g. Referral to Medical Services
h. Statistical sampling for future cost avoidance

Step 2: The Reviewer may consult with additional PI staff when considering the scope, focus, or dispensation of a review. Every review project is unique and the PI unit works as a team to ensure optimal effectiveness and accuracy in the review process.

a. The above recommendation is presented to the Senior Reviewer.

b. The Senior Reviewer may approve action as recommended by the Reviewer, suggest an alternate plan, or request additional information.

☑ *LEVEL 3: Date Case was Approved*

(This is the level in which the full review process begins)

Step 1. In the course of the preliminary or a full review, the Reviewer analyzes available data and requests additional applicable data through all available resources (PI Full Review).

a. SURS Subsystem Reports
b. Data Warehouse Queries (*Requesting Data from Data Warehouse*)
c. MMIS claims information
d. Medical records requested and obtained from providers (*Initiating a Request for Medical Records*)

Step 2. The Reviewer also researches the following sources.

a. Iowa Code (IC)
b. Iowa Administrative Code (IAC)
c. Iowa Medicaid Provider Manuals
d. Code of Federal Regulations (CFR)
e. Medicare Guidelines
f. CMS (Center for Medicare and Medicaid Systems) Guidelines
g. CPT (Procedure) Codes
h. ICD-9 (Diagnosis) Codes
i. HCPCS (Health Care Procedure Codes)

Step 3. The Reviewer documents issues identified in the review, along with references from the list above. (Directory of Codes and Issues).

Step 4. In the course of the review and implementation of action plans, the Review may interface with all members of the PI team. The Reviewer may need to collaborate with other IME or DHS Units.

a. Policy Unit
b. Provider Services
c. Medical Services
d. Member Services
e. Waiver Services
f. Home and Community Based Services (HCBS)
g. Point of Service (POS) and Pharmacy
h. Core and Mailroom
i. Provider Cost Audit
j. Attorney General

Step 5. Determining the time frame to be reviewed may require consultation with the Senior Reviewer or Database Management Administrator.

a. When pulling a statistically valid random sample to be used for extrapolation, a two-to-three year time period is generally considered valid.
b. When planning for actual recoupment, the review should be for the maximum timeframe that is practical and feasible. Providers are required to maintain records for five years, the maximum timeframe for recoupment.

☑ LEVEL 4: Date of Findings Order for Repayment Letter

Step 1. The results of the final review or reevaluation may culminate in any or several of the following.

a. Recoupment of overpayment to providers
b. Provider education
c. Notification of findings of correct claims and payments
d. Systems or operational changes for future cost avoidance
e. Proposed policy change
f. Proposed provider manual changes
g. Proposed change in Iowa Administrative Code
h. Proposed change in MMIS (Change Management Request=CMR).

Refer to procedure for *Reviewer Follow-up*.

☑ ***LEVEL 5: Date Case was Closed***

Step 1: Following is a list of categories for case closure.

a. No errors discovered; no recoupment requested; letter sent.
b. Notice of recoupment sent followed by full receipt of payment from provider.
c. Notice of recoupment sent followed by credit adjustments (claims off-set) to the provider's account.
d. Findings letter resulting in an appeal process. This process ultimately culminates in payment by provider or revised findings without recoupment.

Step 2: Upon closure, the Reviewer then makes a summary recommendation using, "Review Change or Closure" form (PI F-105).

a. The Reviewer should complete the form electronically and send to the Senior Reviewer for approval.
b. The Senior Reviewer, once approved, will complete the form.
c. The Senior Reviewer will process the request and coordinate completion of remainder of tasks.
d. The Reviewer completes the remaining closing tasks after notification of approval from the Senior Reviewer.
e. The Reviewer will close out case review file (folder) and deliver to the Administrative Assistant for scanning and filing.

Refer to procedure for Review Change or Closure.

FORMS/REPORTS:

None

RFP References:
6.1.2.2.6

Interfaces:
All IME Units

Attachments:
None